2" x 2" Photo Here 4600 KIETZKE LANE, SUITE M-245 RENO, NEVADA 89502 (775) 688-1921

DO NOT FAX APPLICATIONS

APPLICATION FOR CERTIFICATION OF CHIROPRACTOR'S ASSISTANT

THE FOLLOWING MU	IST ACCOMPANY T	HIS APPLICAT	ION:		1
1 \$138.25 Check, Mor					
2 One (1) completed t					
3 Signed and dated ci		orm			
4 A recent passport-ty	pe photograph				
	ure to answer ALL ques ARE NOT REFUN		ely and <u>truth</u>	<u>ully</u> will res	sult in denial of this application.
TYPE OR PRINT ONL	Y:				
NAME		WORK E	MAIL:		SEX:MF
CURRENT RESIDENCE ADDRESS					
CITY/STATE/ZIP					TELEPHONE
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employer's name					
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CITY/STATE/ZIP					EMPLOYER'S PHONE & FAX
List all states where the current status of		ed for certificatio	on as a Chirop	ractor's Ass	sistant, the result of each application, and
					e you now or have you ever been the eding of a like nature:
YES	_ NO If yes, n	ame the state a	nd give dispos	sition of cha	arges:
-					

	-	records sealed a		-		-	e any DUI's)? NOTE: Even if report this information,
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4.	-				•		E: Even if you have had rmation, including juvenile
	YES _	NO	If yes, name the	state and give	disposition:		_
5.	Have you ever	defaulted on a	a HEAL (Health Educa	ation Assistanc	:e Loan)?		
			If yes, give detail				
6.	Have you ever	been drug or a	alcohol dependent ar	nd/or enrolled	in a drug or alcol	nol rehabilitation	n program?
	YES _	NO	If yes, give detail	Is and current :	status:		
	Branch(es) of S	Service					
8.	Please mark the THE BOXES BE	e appropriate r LOW WILL RES	esponse regarding of SULT IN DENIAL OF	child support -	even if you ha	ve no children	1 (FAILURE TO MARK ONE OF
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TOTAL NUMBER OF CLASSROOM HOURS ATTENDED: IF YOU HAVE ALREADY RECEIVED FORMAL TRAINING AS A CHIROPRACTOR'S ASSISTANT AND COMPLETED NO. 1, SKIP NO. 2 AND 3 AND SIGN AT THE BOTTOM OF THIS PAGE IN THE PRESENCE OF A NOTARY. NOTE: TO APPLICANTS WHO ARE APPLYING FOR CERTIFICATION UNDER THE PROVISION FOR ON-THE-JOB TRAINING APPLICATIONS MUST BE SUBMITTED WITHIN 15 DAYS OF BEGINNING OF TRAINING. 2. ON-THE-JOB TRAINING IN CHIROPRACTIC FACILITY 3. ON-THE-JOB TRAINING IN A HEALTH CARE FACILITY OTHER THAN CHIROPRACTIC IF 2 OR 3 ABOVE APPLY, PLEASE COMPLETE THE FOLLOWING: WHE OF PERSON RESPONSIBLE FOR YOUR TRAINING AFFIDAVIT: The undersigned, being duly sworn under penalty of perjury, deposes and says that the statements contain herein are true, complete and correct to the best of his/her knowledge and belief; that he/she has no suppressed any information which might affect this application; that he/she has not omitted any information to his/her current fitness to practice; that he/she is of good moral character and will conform to the thical standards and conduct of the chiropractic profession; that he/she will notify the CPBN of any and changes to the information in this application, including changes of address and that he/she has not entered and sull statutory requirements and will ablied by the provisions of NRS and NAC 634 including that he/she will notify the CPBN of any and changes to the information and will ablied by the provisions of NRS and NAC 634 including that he/she will notify the CPBN of any and changes to the information and will ablied by the provisions of NRS and NAC 634 including that he/she will notify the CPBN of any and changes to the information and will ablied by the provisions of NRS and NAC 634 including that he/she will notify the CPBN of any and changes to the information in this application, including changes of address and that he/she will notify the CPBN of any and changes to the information in this application, including changes of address and that he/she has not the provisions of	1.	FORMAL PROGRAM	(TRANSCRIPT I	MUST BE SENT	FROM SCHOOL	L)	
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